MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF RURAL HEALTH AND PRIMARY CARE
P.O. BOX 570, JEFFERSON CITY, MO 65102-0570

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM

ALL INFORMATION IS CONFIDENTIAL AND FOR PROGRAMMATIC PURPOSES ONLY

MUST BE TYPED OR PRINTED

SECTION 1 – APPLICANT'S PERSONAL INFORMATION

APPLICANTS LAST NAME	FIRST NAME	MI.	APPLICANTS SOCIAL SECURITY NUMBER

OTHER NAMES USED LAST NAME	FIRST NAME	MI.

DATE OF BIRTH	SOCIAL SECURITY NUMBER	HOME TELEPHONE NUMBER	CELL PHONE NUMBER

☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED

AGES OF DEPENDENTS

PRESENT ADDRESS STREET	CITY	STATE	ZIP

LANGUAGES SPOKEN FLUENTLY OTHER THAN ENGLISH	US CITIZEN ☐ YES ☐ NO

LAST NAME OF SPOUSE	FIRST NAME	MI.	SPOUSE SOCIAL SECURITY NUMBER

SPOUSE'S OCCUPATION

NAME OF RELATIVE NOT LIVING WITH YOU	RELATIONSHIP TO YOU

RELATIVE STREET ADDRESS	CITY	STATE	ZIP	RELATIVE HOME TELEPHONE NUMBER

SECTION 2 – APPLICANTS EMPLOYMENT INFORMATION

PRESENT EMPLOYER	STREET ADDRESS	CITY	STATE	ZIP

DATE EMPLOYED	YOUR TITLE	SUPERVISORS NAME

WORK TELEPHONE AND EXTENSION	THIS FACILITY IS	COUNTY
( )	☐ PUBLIC ☐ NON-PROFIT ☐ FOR PROFIT	

PERCENT OF PRACTICE TIME

_____ % DIRECT PATIENT CARE _____ % ADMINISTRATION _____% HOSPITAL ROUNDS _____% TEACHING

SECTION 3 – APPLICANTS NURSING/RESIDENCY PROGRAM INFORMATION

NAME OF LAST SCHOOL/RESIDENCY PROGRAM ATTENDED	TELEPHONE NUMBER ( )

SCHOOL ADDRESS STREET	CITY	STATE	ZIP

LIST TYPE AND DATE YOU COMPLETED REQUIREMENTS FOR YOUR DEGREE, DIPLOMA OR RESIDENCY

☐ ASSOCIATE NURSING DEGREE
☐ DIPLOMA NURSING DEGREE
☐ BACHELOR NURSING DEGREE
☐ ADVANCED NURSE PRACTITIONER
☐ DOCTOR OF ALLOPATHIC MEDICINE
☐ DOCTOR OF OSTEOPATHIC MEDICINE
☐ DEGREE IN DENTAL SCIENCES
☐ RESIDENCY _____ (TYPE)

DATE COMPLETED (MM/DD/YYYY)

ARE YOU CURRENTLY HOLDING PERMANENT MISSOURI LICENSE OR CERTIFICATION?	IF YOU ARE A PHYSICIAN ARE YOU BOARD CERTIFIED?
☐ YES ☐ NO	☐ YES ☐ NO

MISSOURI LICENSE NUMBER	MISSOURI BOARD CERTIFICATION NUMBER

LIST ANY OTHER STATES WHERE YOU ARE LICENSED TO PRACTICE AND YOUR LICENSE NUMBER

DO YOU HAVE AN EXISTING SERVICE OBLIGATION?	ARE YOU IN DEFAULT OF THIS OBLIGATION?
☐ YES ☐ NO	☐ YES ☐ NO

IF YES, NAME OF PROGRAM	TELEPHONE NUMBER ( )	DATE OBLIGATION COMPLETE

HAVE YOU EVER DEFAULTED ON A LOAN?
☐ YES ☐ NO

IF YES, LIST NAME OF LOAN, TYPE OF LOAN AND REASON FOR DEFAULT.

The Missouri Department of Health and Senior Services enhances quality of life for all Missourians by protecting and promoting the community's health and the well-being of citizens of all ages.

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM

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COMPLETE FOR EACH LOAN YOU WISH TO BE INCLUDED IN THE AGREEMENT. THIS AUTHORIZES YOUR LENDER TO VERIFY TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES THE EDUCATIONAL LOANS YOU HAVE DESCRIBED BELOW AND TO DISCLOSE THE AMOUNT OWED TO THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES.

LENDING INSTITUTION OR CURRENT HOLDER OF LOAN	ACCOUNT NUMBER	BALANCE	CONTACT PERSON	ADDRESS OF CONTACT PERSON STREET, CITY, STATE, ZIP	TELEPHONE NUMBER
1.					
2.					
3.					
4.					
5.					

APPLICATIONS WITHOUT APPROPRIATE ATTACHMENTS WILL NOT BE PROCESSED. THE FOLLOWING INFORMATION MUST BE ATTACHED.

HAVE YOU ENCLOSED?

ALL APPLICANTS (MD, DO, D.D.S., RN, APN)

- ☐ LETTER OF SUPPORT FROM YOUR EMPLOYER
- ☐ COPY OF YOUR ORIGINAL PROMISSORY NOTE(S)
- ☐ COPY OF YOUR SITE CONTRACT
- ☐ COPY OF YOUR CURRENT LICENSE
- ☐ PERCENT OF MEDICAID PATIENTS SEEN

PHYSICIANS

- ☐ PROOF OF YOUR BOARD ELIGIBILITY OR CERTIFICATION

REGISTERED NURSES

- ☐ COPY OF YOUR OFFICIAL JOB DESCRIPTION
- ☐ DESCRIPTION OF SERVICES PROVIDED BY EMPLOYER

ADVANCE PRACTICE NURSES

- ☐ COPY OF YOUR DOCUMENT OF RECOGNITION
- ☐ COPY OF YOUR OFFICIAL JOB DESCRIPTION
- ☐ DESCRIPTION OF SERVICES PROVIDED BY EMPLOYER

The undersigned hereby authorized the full disclosure of any information regarding the nature, amount, terms and status of this loan for the purpose of entering an agreement with the Missouri Department of Health and Senior Services for repayment of said loans.

The undersigned hereby certifies the accuracy of the information in the application and applies to enter into an agreement with the Missouri Department of Health and Senior Services for repayment of a portion of the educational loans listed above.

PLEASE PRINT FULL NAME

SIGNATURE

DATE